

CERTIFICATE OF DEATH

Reg. Dist. No.

01132

1143

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Bernard Last Abell				4. DATE OF DEATH Month January Day 21 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1893	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Post Office and		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Perry Abell			
14. MOTHER'S MAIDEN NAME Sarah Fulton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216-01-9973				17. INFORMANT Mrs Florine D. Abell Clements, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Heart failure							INTERVAL BETWEEN ONSET AND DEATH 30 yrs. 10 years. 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-50 , 19____, to 1-21-60 , 19____, that I last saw the deceased alive on 1-21-60 , 19____, and that death occurred at 12:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.D. Patrick				ADDRESS (Street, city or town, state) Lexington Park Md 21-60			
PHYSICIAN'S NAME (Type) William H. Patrick M.D.				DATE SIGNED 1-21-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/60		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE JAN 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1943

10-10-43

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		e. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Frank - Caldwell		4. DATE OF DEATH January 21 19 60	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH ? 1895 ?
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		17. INFORMANT Nellie B. Caldwell - Winston Salem, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate 6 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE P.J. Bean, MD		DATE SIGNED 1/21/60	
EXAMINER'S NAME (Type) P.J. Bean, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/60	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Winston Salem, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR JAN 27 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1145 CERTIFICATE OF DEATH

Reg. Dist. No.

01134

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River				c. LENGTH OF STAY IN 1b 3 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Moody Last CHANDLER				4. DATE OF DEATH Month January Day 25 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1921 38 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviation Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry B. Chandler		14. MOTHER'S MAIDEN NAME Hattie Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1939/1959		16. SOCIAL SECURITY NO. 256 03 5641		17. INFORMANT Wife: Dorothy W. Chandler, California, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 25 January 1960 , to 25 January 1960 , that I last saw the deceased alive on 25 January 1960 , and that death occurred at 3:00 PM , from the causes and on the date stated above. John H. Edmonds, Jr. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE JOHN H. EDMONDS, Jr. LT MC USNR USNAS, Patuxent River, Md. 1-25-60 PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/60		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Prusa	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 5. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1133 CERTIFICATE OF DEATH

Reg. Dist. No.

01135

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 10 weeks 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Maude Last Combs		4. DATE OF DEATH Month January Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1904
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lived at home with Mother and brother	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Thomas Combs	
14. MOTHER'S MAIDEN NAME Annie May Cecil		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Mrs James T. Combs		17. INFORMANT Address Great Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Anemia secondary DUE TO (b) Metastatic carcinoma (brain) DUE TO (c) Carcinoma uterus (body) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months 6 months 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1957 to Jan 19, 1960 , that I last saw the deceased alive on Jan 18, 1960 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. J. Bean M.D.		DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type) P. J. Bean M.D.		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Face		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR JAN 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1133

10-1-52

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1133

1133

CERTIFICATE OF DEATH

Reg. Dist. No.

1146

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Callaway		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanche Middle Victoria Last Combs		4. DATE OF DEATH Month January Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James R Redmond		14. MOTHER'S MAIDEN NAME Deliah Ellen Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. none	
INFORMANT James M. Combs		Address Callaway, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) acute dilatation of heart DUE TO (b) chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5 , 19 56 , to Jan 4 , 19 60 , that I last saw the deceased alive on Dec 1 , 19 59 , and that death occurred at 3:4 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles Greenwell M.D.			
PHYSICIAN'S NAME (Type) Charles Greenwell M. D.		Leonardtwn, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/7/59 60	22c. NAME OF CEMETERY OR CREMATORY Holy Face	22d. LOCATION (City, town, or county) (State) Great Mills, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE JAN 7 '60	
ADDRESS Leonardtwn, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1946

St. Louis

Male

White

James H. Johnson

White

Male

None

Nov. 7, 1901

St. Louis

None

None

James H. Johnson

St. Louis

St. Louis

James H. Johnson

None

None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01137

1134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Idell Last Combs		4. DATE OF DEATH Month January Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min.	11. IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Courtney		14. MOTHER'S MAIDEN NAME Edith Foxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leroy Combs		Address Ridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 minutes 10 yrs 15 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1935 to Jan 15, 1960 that I last saw the deceased alive on Jan 15, 1960 , and that death occurred at 5 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 1/16/60			
ACTUAL SIGNATURE P.J. Bean		PHYSICIAN'S NAME (Type) P.J. Bean M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/60	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's		22d. LOCATION (City, town, or county) (State) Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR JAN 21 '60	
ADDRESS Leonardtwn, Maryland		24b. REGISTRAR'S SIGNATURE Charles E. Thomas	

078

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MEDICAL CERTIFICATION

1000 MATE

CERTIFICATE OF DEATH

1130

DATE OF DEATH

PLACE OF DEATH

AGE

NAME OF DECEASED

SEX

RACE

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

OFFICE

1135 CERTIFICATE OF DEATH

01138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Walter Walter Cryer				4. DATE OF DEATH Month Day Year January 16 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1885	
9. AGE (In years lost, birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Office				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Cryer				14. MOTHER'S MAIDEN NAME Mary Elizabeth Mattingley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Mrs Antoinette			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 22 , 19 56 , to Jan 16 , 19 60 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles Greenwell M.D.							
PHYSICIAN'S NAME (Type) Charles Greenwell M. D.				Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/60		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE JAN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knap	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1136

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtoun		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Cullins		4. DATE OF DEATH Month January Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1980
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Edward Cullins		14. MOTHER'S MAIDEN NAME Mary Elizabeth Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Martha Belle Cullins Avenue, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days over 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 9, 1954 to January 25, 1960 , that I last saw the deceased alive on January 25, 1960 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert F. Fuchs		ADDRESS (Street, city or town, state) Leonardtoun, Md. DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/60	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Bushwood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtoun, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fuchs	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1136



[The following text is mirrored bleed-through from the reverse side of the document and is largely illegible due to fading and orientation.]

NAME OF DECEASED: _____

AGE: _____

SEX: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

TIME OF DEATH: _____

CAUSE OF DEATH: _____

SIGNATURE OF PHYSICIAN: _____

SIGNATURE OF WITNESS: _____

DATE: _____

Reg. Dist. No.

MEDICAL CERTIFICATION

1131

Intercepted

Bill

CERTIFICATE OF DEATH

Reg. Dist. No.

01141

1138

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY <input checked="" type="checkbox"/>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			c. LENGTH OF STAY IN 1b 30 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS Rural Bellingham 58X-3		
3. NAME OF DECEASED (Type or print) First Martha Middle Mellish Last Hood			4. DATE OF DEATH Month January Day 17 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1882		9. AGE (In years lost birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Mellish			14. MOTHER'S MAIDEN NAME ? ? Moore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	INFORMANT Address Constance H. Rice 510 Enterprise Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Hypostatic Pneumonia DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lexington Park, Md.	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Dec 18, 1959 to Jan 17, 1960 that I last saw the deceased alive on Jan 17, 1960 and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE W.H. Patrick		ADDRESS (Street, city or town, state) Lexington Park, Md.		DATE SIGNED Jan 18-60	
PHYSICIAN'S NAME (Type) William H. Patrick M.D. Lexington Park, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/60		22c. NAME OF CEMETERY OR CREMATORY River Street	
22d. LOCATION (City, town, or county) (State) Woodstock, Vermont					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland			24a. REC'D BY REGISTRAR JAN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 254 1-18-60 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

01142

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U. S. Naval Air Station	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 935-B, MOQ		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Miriam Middle Lois Last KESTER		4. DATE OF DEATH Month January Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 November 1913
9. AGE (In years last birthday) 46 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
13. FATHER'S NAME John Norton		14. MOTHER'S MAIDEN NAME Media Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Husband: Karl H. Kester, Patuxent River, Md.		Address 935-B, MOQ, USNAS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage, massive, acute 330X DUE TO spontaneous, etiology not determined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis, aorta and coronary arteries, moderate Obesity; Pulmonary congestion; Myocardial fibrosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 _____, to _____, 19 _____, that I last saw the deceased alive at _____, _____, and that death occurred at _____, _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Armstrong M.D.		ADDRESS (Street, city or town, state) USNAS, Patuxent River, Md. DATE SIGNED 1-7-60	
PHYSICIAN'S NAME (Type) J. H. ARMSTRONG, LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE W. Clark Hattingly, Leonardtown, Md		24a. REC'D BY REGISTRAR JAN 12 60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

PLACE OF BIRTH COUNTY		MARITAL SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
DATE OF BIRTH YEAR MONTH DAY		DATE OF DEATH YEAR MONTH DAY	
SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		RACE WHITE <input type="checkbox"/> COLORED <input type="checkbox"/>	
OCCUPATION TRADE PROFESSION SERVICE		CAUSE OF DEATH DISEASE INJURY POISON OTHER	
PLACE OF DEATH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/>		PLACE OF BIRTH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/>	
NAME OF PHYSICIAN NAME OF HOSPITAL NAME OF NURSING HOME NAME OF OTHER		NAME OF CORONER NAME OF JURY NAME OF OTHER	
SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER SIGNATURE OF JURY SIGNATURE OF OTHER		SIGNATURE OF PHYSICIAN SIGNATURE OF CORONER SIGNATURE OF JURY SIGNATURE OF OTHER	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>67 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Wesley Lucas</u>				4. DATE OF DEATH Month Day Year <u>Jan. 9 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 3, 1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Ned Lucas</u>				14. MOTHER'S MAIDEN NAME <u>Betty Ann Swann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Pulmonary Embolism</u> DUE TO (b) <u>Anticoagulants</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post operative fracture of hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>59</u> , to <u>Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7 Jan</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Charlotte Hall Md</u> DATE SIGNED <u>Arthur S. Kraus</u>							
ACTUAL SIGNATURE <u>David Mossman</u> M.D. <u>Neckerson & Galt</u>							
PHYSICIAN'S NAME (Type) <u>David Mossman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>All Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Charlotte Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01144

1148

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leonardtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? NO		
3. NAME OF DECEASED (Type or print) First Clara Middle Noema Last Mattingly			4. DATE OF DEATH Month January Day 3 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1882		9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Allie Hayden			14. MOTHER'S MAIDEN NAME Alice Abell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT R. Paul Mattingley Leonardtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan 3 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE P. J. Bean M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/60		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	
				22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Mary's

Maryland

Dr. Mary's

John Leonardtown

John

John

John Leonardtown

John

John

John

John

Female

John

April 20, 1982

John

House wife

John

Maryland

U.S.A.

Alfred Hayden

Alfred Hayden

John

John Leonardtown, Maryland

P. J. Bean M. D.

St. Joseph's

Maryland

John Leonardtown, Maryland

1140 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mazie Middle Morgan Last Mattingly		4. DATE OF DEATH Month January Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Clements, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Morgan		14. MOTHER'S MAIDEN NAME Margaret Dosie Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Joseph B. Mattingly		Address Abell, Maryland	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) Squamous Carcinoma of nasopharynx, metastatic to lungs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5 , 19 57 , to Jan , 19 60 , that I last saw the deceased alive on Jan 14 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED David Mossman M. D. Mechanicsville, Maryland 1-18-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/60	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR JAN 21 '60	
ADDRESS Leonardtown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1140

1141

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

NAME: _____

DATE: _____

PLACE: _____

CAUSE: _____

SIGNATURE: _____

ORIGINAL FILED

RECORDED

INDEXED

CERTIFICATE OF DEATH

Reg. Dist. No.

01146

1148

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Joy Mosher		4. DATE OF DEATH Month Day Year January 1 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley Mosher		14. MOTHER'S MAIDEN NAME Effie Joy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) -----	
17. INFORMANT Lida E. Mosher - Hollywood, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1960 , to 1/11 , 19 60 , that I last saw the deceased alive on 19 , and that death occurred at 2:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leonardtwn, Md. 1/1/60			
ACTUAL SIGNATURE Charles Greenwell M.D.		PHYSICIAN'S NAME (Type) Charles Greenwell, MD Leonardtwn, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/60	22c. NAME OF CEMETERY OR CREMATORY Hollywood Methodise	22d. LOCATION (City, town, or county) (State) Hollywood, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JAN 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35		4. DATE OF DEATH 10/10/1918	
5. PLACE OF DEATH Home		6. CITY OR TOWN Baltimore		7. COUNTY Baltimore		8. STATE Maryland	
9. OCCUPATION None		10. CAUSE OF DEATH Pneumonia		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. J. Jones	
13. NAME OF NEXT OF KIN Mrs. J. J. Jones		14. ADDRESS 1234 N. Main St.		15. CITY Baltimore		16. STATE Maryland	
17. NAME OF WITNESS J. J. Jones		18. ADDRESS 1234 N. Main St.		19. CITY Baltimore		20. STATE Maryland	
21. NAME OF WITNESS J. J. Jones		22. ADDRESS 1234 N. Main St.		23. CITY Baltimore		24. STATE Maryland	
25. NAME OF WITNESS J. J. Jones		26. ADDRESS 1234 N. Main St.		27. CITY Baltimore		28. STATE Maryland	
29. NAME OF WITNESS J. J. Jones		30. ADDRESS 1234 N. Main St.		31. CITY Baltimore		32. STATE Maryland	
33. NAME OF WITNESS J. J. Jones		34. ADDRESS 1234 N. Main St.		35. CITY Baltimore		36. STATE Maryland	
37. NAME OF WITNESS J. J. Jones		38. ADDRESS 1234 N. Main St.		39. CITY Baltimore		40. STATE Maryland	
41. NAME OF WITNESS J. J. Jones		42. ADDRESS 1234 N. Main St.		43. CITY Baltimore		44. STATE Maryland	
45. NAME OF WITNESS J. J. Jones		46. ADDRESS 1234 N. Main St.		47. CITY Baltimore		48. STATE Maryland	
49. NAME OF WITNESS J. J. Jones		50. ADDRESS 1234 N. Main St.		51. CITY Baltimore		52. STATE Maryland	
53. NAME OF WITNESS J. J. Jones		54. ADDRESS 1234 N. Main St.		55. CITY Baltimore		56. STATE Maryland	
57. NAME OF WITNESS J. J. Jones		58. ADDRESS 1234 N. Main St.		59. CITY Baltimore		60. STATE Maryland	
61. NAME OF WITNESS J. J. Jones		62. ADDRESS 1234 N. Main St.		63. CITY Baltimore		64. STATE Maryland	
65. NAME OF WITNESS J. J. Jones		66. ADDRESS 1234 N. Main St.		67. CITY Baltimore		68. STATE Maryland	
69. NAME OF WITNESS J. J. Jones		70. ADDRESS 1234 N. Main St.		71. CITY Baltimore		72. STATE Maryland	
73. NAME OF WITNESS J. J. Jones		74. ADDRESS 1234 N. Main St.		75. CITY Baltimore		76. STATE Maryland	
77. NAME OF WITNESS J. J. Jones		78. ADDRESS 1234 N. Main St.		79. CITY Baltimore		80. STATE Maryland	
81. NAME OF WITNESS J. J. Jones		82. ADDRESS 1234 N. Main St.		83. CITY Baltimore		84. STATE Maryland	
85. NAME OF WITNESS J. J. Jones		86. ADDRESS 1234 N. Main St.		87. CITY Baltimore		88. STATE Maryland	
89. NAME OF WITNESS J. J. Jones		90. ADDRESS 1234 N. Main St.		91. CITY Baltimore		92. STATE Maryland	
93. NAME OF WITNESS J. J. Jones		94. ADDRESS 1234 N. Main St.		95. CITY Baltimore		96. STATE Maryland	
97. NAME OF WITNESS J. J. Jones		98. ADDRESS 1234 N. Main St.		99. CITY Baltimore		100. STATE Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1141 CERTIFICATE OF DEATH

Reg. Dist. No.

01147

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Porter		4. DATE OF DEATH Month January Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk, House wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Washington Bennett		14. MOTHER'S MAIDEN NAME Mary Emily Wheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-22-2186	
INFORMANT Miss Jennie Bennett		Address Leonardtwn, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma of Rectum DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH about 3 mths over 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1 , 19 56 , to January 8 , 19 60 , that I last saw the deceased alive on December 31 , 19 59 , and that death occurred at 3:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert F. Fuchs		ADDRESS (Street, city or town, state) Leonardtwn, Md. DATE SIGNED 1/8/60	
PHYSICIAN'S NAME (Type) Robert Fuchs M. D.		Leonardtwn, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/11/60	22c. NAME OF CEMETERY OR CREMATORY St. Paul's	22d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Maryland	
24a. REC'D BY REGISTRAR JAN 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

Miss Jennie Bennett Leonardtown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01148

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charlotte Hall</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charlotte Hall</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Carroll</i> Middle <i>Elmore</i> Last <i>Reed</i>			4. DATE OF DEATH Month <i>Jan.</i> Day <i>25</i> Year <i>1960</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27 1907</i>	9. AGE (In years last birthday) <i>52 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Mechanicsville Maryland</i>	
13. FATHER'S NAME <i>Wheatley Reed</i>			14. MOTHER'S MAIDEN NAME <i>Mechanics R Chesley</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Ellin Lillian Reed</i> Address <i>Charlotte Hall Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Excess exposure to cold</i> <i>932.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>					INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>acute alcoholism</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Fell asleep on front porch in 12° degree weather</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>1 25 50</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Charlotte Hall</i>	(County) <i>St Mary</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William D. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1/25/60</i>	
EXAMINER'S NAME (Type) <i>William D. Boyd M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/27/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's</i>		22d. LOCATION (City, town, or county) (State) <i>Morganza Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>		ADDRESS <i>Leonardtwn, Maryland</i>		24a. REC'D BY REGISTRAR <i>FEB 1 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1151 CERTIFICATE OF DEATH

Reg. Dist. No.

01149

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hollywood		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maurice Middle Chapman Last Thompson		4. DATE OF DEATH Month January Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Chapman Thompson		14. MOTHER'S MAIDEN NAME Jane Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Catherine S. Thompson Hollywood, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral, oral pharynx 145.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 57 , to Dec , 19 59 , that I last saw the deceased alive on Oct , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Maryland DATE SIGNED Dec 1959 ACTUAL SIGNATURE David Messman M.D. PHYSICIAN'S NAME (Type) David Messman Mechanicsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/60	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR JAN 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

1114

1151

1

1

STATE OF NEW YORK
IN SENATE
January 11, 1911
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1909
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1911

CERTIFICATE OF DEATH

Reg. Dist. No.

01150

1142

1. PLACE OF DEATH a. COUNTY St. Mary's County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Edwing Last Wathen Jr.		4. DATE OF DEATH Month January Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-60
9. AGE (In years lost birthday) — yrs.		10. IF UNDER 1 YEAR Months — Days 1	11. IF UNDER 24 HRS. Hours 12 Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph Edwing Wathen		14. MOTHER'S MAIDEN NAME Barbara Ann Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 760.5 IMMEDIATE CAUSE (a) Intracranial hemorrhage? DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/16 , 19 60 , to 1/16 , 19 60 that I last saw the deceased alive on 1/16 , 19 60 , and that death occurred at 2:05 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED			
ACTUAL SIGNATURE J. Roy Guyther M.D.			
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/18/60	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE JAN 21 '60 24b. REGISTRAR'S SIGNATURE Arthur S. K...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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CERTIFICATE OF DEATH

1102

Deceased

St. Paul's Hospital

Age

Sex

Occupation

Place of Birth

Married

Single

Widow

Date

Time

Place of Death

Cause of Death

Signature

Witness

Handwritten signature

Handwritten signature

Medical Officer

Registrar

St. Paul's Hospital

1102

1102

Witnessed by